## 7 – 8 Years Old AHCCCS EPSDT Tracking Form

| Date | Last Name | First Name | AHCCCS ID # | DOB | Age |
|---|---|---|---|---|---|
| | | | | | |

| Primary Care Provider | PCP ph. # | Health Plan | Accompanied by (name) | Relationship |
|---|---|---|---|---|
| | | | | |

| NICU: ☐ yes ☐ no | PEDS ☐ yes ☐ no | PEDS Pathway: | Vision Chart Exam | | | Allergies: | Temp: | Pulse: | Resp: | B/P |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | OD | OS | OU | | | | | |
| Audiometry | | | Corrected ☐ yes ☐ no | | | Wt: | % | BMI: | % | Ht: % |
| ☐ WNL | ☐ Abnormal | | | | | | | | | |
| Speech: age appropriate ☐ yes ☐ no | | Medications: | | | | | | | | |

**PARENTAL/PATIENT CONCERNS/HISTORY:**

**DENTAL SCREEN:** [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

**NUTRITIONAL SCREEN:** [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

**DEVELOPMENTAL SCREEN:** [X] INDICATES ACCOMPLISHMENTS: ☐ School attendance ☐ Reading at grade level ☐ Other

**AGE APPROPRIATE EDUCATION AND GUIDANCE:** [X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Bullying ☐ Other

**BEHAVIORAL HEALTH SCREEN:** [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family adjustment/parent responds positively to child ☐ Frustration /impulse control ☐ Communication/language ☐ Comfortable body image ☐ Pediatric Symptom Checklist ☐ Other

**COMPREHENSIVE PHYSICAL EXAM:**

| | WNL | Abnormal (see notes below) | | WNL | Abnormal (see notes below) |
|---|---|---|---|---|---|
| Skin/Hair/Nails | | | Lungs | | |
| Eyes/Vision | | | Abdomen | | |
| Ear | | | Genitourinary | | |
| Mouth/Throat/Teeth | | | Extremities | | |
| Nose/Head/Neck | | | Spine | | |
| Heart | | | Neurological | | |

**ASSESSMENT/PLAN/FOLLOW UP**

| | |
|---|---|
| **LABS ORDERED:** | [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other |
| **IMMUNIZATIONS:** | [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hep A ☐ MMR ☐ Varicella ☐ Td ☐ Influenza ☐ Hep B ☐ IPV ☐ Other |
| **REFERRALS:** | [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty |

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**